

Eye Diseases

PREVENTION OF BLINDNESS DEPARTMENT

New York State Commission for the Blind

80 Centre Street

New York City

DISEASES OF THE LIDS AND CONJUNCTIVA*

H. Robertson Skeel, M.D., New York, N. Y.

THE nurse and social worker see many cases of lid and conjunctival diseases during the day's activities. These brief descriptions of the various types most frequently noted with the symptoms and treatment are intended to supplement their own knowledge, enabling them to render valuable educational and preventive service to their communities.

Pneumococcus infections of the lids are quite common types but not very dangerous to the eye unless the cornea is involved. They often clear up abruptly, almost like a crisis in pneumonia. The lids and bulbar conjunctiva become oedematous; the conjunctiva is sometimes spotted with small hemorrhages; and there is a thin, watery, serous discharge similar to a copious discharge of tears but unlike the thick gummy pus so often seen in an acute catarrhal conjunctivitis. After running a course of six to eight days, the eyes will begin to improve on the ninth day; and on the tenth day the lids will open. By the twelfth day the eyes will be almost well.

Treatment consists mainly of cleanliness and irrigation and the use of mild antiseptics. Except for gonorrheal infections most of these conditions are self limited; they are dangerous only when they show complications to the eye itself.

The next type is that called Koch-Weeks infection because the infecting organism is the Koch-Weeks bacillus, first discovered by

* Abstract of paper presented at the Institute on Conservation of Vision given under the auspices of the New York State Department of Social Welfare, Commission for the Blind, Prevention of Blindness Department, October 29, 1931.

Koch with further research by Dr. Weeks of New York. It has a very typical involvement, that is, in contra-distinction to the pneumococcus infection. The Koch-Weeks infection produces a thick muco-purulent discharge and a swelling of the angles of the lids which are very much thickened. Photophobia is pronounced as well as pain which may be referred down to the jaw or the preauricular gland. Sometimes the face swells slightly and the patient suffers intensely. Meanwhile the discharge continues to become thicker and the lids, which become very hard, infiltrated and oedematous, are gummed together.

This type of infection, which is highly contagious and which may spread from one individual to a whole neighborhood, should be isolated. The eyes should be kept clean by careful cleansing, mild instillations of zinc solution should be used, and the patient should be removed from contact with other cases. Fortunately, the disease runs a rapid course and does not cause severe complications.

Then there is the diphtheric type. Cases of this kind, however, are not often encountered, since diphtheria has decreased. Although some discharge may be present, it is not very profuse but the lids are hard. When the lids are everted, especially the upper lid, a grayish membrane on which is formed a dirty gray exudate may be noted. Since this membrane is quite firmly attached, it will bleed and cause a great deal of pain if any attempt is made to remove it.

"Pink Eye," another eye infection, is caused by streptococci or staphylococci. Routine treatment in the form of silver instillations and irrigations is given. Without complications, practically no eye has ever been lost from the ordinary "Pink Eye."

Ophthalmia neonatorum usually manifests itself on the third day postpartum. There are great swelling of the lids and serous infiltration of the bulbar conjunctiva—sometimes so extensive that the conjunctiva protrudes between the lids. A serious complication and a great danger of this disease is the corneal involvement which frequently occurs. Corneal ulcers result and may cause perforation with more or less serious consequences, according to the extent of the perforation. The ulcerated cornea may also yield to pressure from within, which causes it to bulge forward, producing a staphyloma or incarcerated iris, and may lead to ultimate blindness.

Even though this disease is now under better control, due to silver instillations and similar prophylactic measures, it must still be guarded against. A newborn child who shows any redness or disturbance of the lids or conjunctiva should immediately be examined carefully by a physician.

Adult gonorrheal conjunctivitis is the straight infection from Neisser's bacillus. Fortunately, it is generally monocular. This disease runs about the same course as ophthalmia neonatorum, except that there is much more congestion. The lids may be so swollen that it is impossible to open them without a lid elevator; even then it may be necessary to scarify them in order to allow the fluid to escape before the cornea can be examined. Here the same complications arise as in ophthalmia neonatorum, but the course is longer and more severe, and quite often the eye is lost. Every precaution should be taken to prevent the second eye from becoming involved. As a means of protection a Buller shield may be used. This shield is merely a watch crystal applied over the eye and bound down to the face with adhesive. By walling off the eye in this way, none of the secretion from the infected eye can enter the other eye.

Tuberculosis of the conjunctiva is a very rare disease, and seldom encountered.

Phlyctenular conjunctivitis, a rather common type of conjunctivitis, is seen most frequently in undernourished children. In these cases a marked photophobia occurs; the patient has a tendency to stay away from the light, constantly blinking his eyes and wiping away the secretion. Although the eye is not severely inflamed it is highly sensitive. Upon examination, a slight elevation on the bulbar conjunctiva—a small reddish yellow mass about the size of a rice flake—is found usually near the edge of the cornea.

Although the ordinary mydriatics relieve the photophobia considerably, attention should be centered upon the improvement of hygienic conditions, general health, diet and personal cleanliness.

Follicular conjunctivitis and trachoma are frequently confused. It is often difficult to differentiate between the two symptoms. In cases where the eye is sensitive, the lids thickened and oedematous with considerable lacrimation, suspicion is aroused. Follicular conjunctivitis can be diagnosed after observation if there is no increase

or coalescence in the elevations; if the bulbar conjunctiva remains clear, and if there are no corneal ulcers.

On the other hand, with trachoma, especially in the acute stages, the condition progresses. The patient shuns the light more and more, marginal corneal ulcers form, and later a few blood vessels running down over the corneal surface gradually obscure the vision when they spread over the pupillary margin. If the disease is allowed to continue without proper care, there is secondary cicatricial change and small fine, white, parallel lines appear along the edge of the lids. Ectropion or entropion may result from the deformity of the tarsus.

Another condition, Saemisch catarrh or vernal catarrh, is also found occasionally and is not infrequently mistaken for trachoma. The disease occurs generally in the fall or in April or May. Lids are thickened and the patient becomes sensitive to light. On eversion of the lids, granular tissue of a peculiar appearance is noticed; the granules are flat and overlap one another just as the shingles of a roof. This condition is often bilateral and does not respond easily to treatment. Fortunately, there is no involvement of the cornea and no harm to the globe, no formation of new blood vessels and no pannus. In cold weather, and as the barometer rises, the disease occurs less frequently and the patient is also more comfortable. Treatment is mostly symptomatic. No exact cure has yet been found. X-rays have been used and scarification, but as in hay fever the condition usually returns.

Most of the ordinary diseases of the conjunctiva that are seen in the usual daily work have been outlined. A few involvements of the lids will now be taken up.

Blepharitis is an inflammation of the edge of the lids. It is not always local but may be secondary to some systemic involvement. There are two types of blepharitis: ulcerative and non-ulcerative.

The ulcerative type is very severe and resistant to treatment. As the term implies, the lids are pitted with small ulcers which form crusts. A definite loss of tissue follows the removal of the ulcers; the eyelashes drop out and the patient suffers considerable discomfort and pain. These cases are quite often caused by some postnasal catarrh or blockage of the tear duct which prevents the normal flow

of tears and keeps the lids irritated. Here the general condition should be treated to eliminate systemic causes.

The non-ulcerative type is less severe. Even though the lids are likely to be thickened, sore and uncomfortable, they respond usually to yellow oxide treatment or any of the mild ointments which keep lids soft and free from crusts. The patient should be restrained from rubbing his eyes.

Another type of blepharitis although an uncommon one is that produced by pediculi. In examining these lid cases it is wise to use a powerful magnifying glass, looking along the eyelashes and their roots to observe any eggs or little white "nits" which may be present. They usually appear at right angles on the lash as a bud on a branch. Castile soap and water are very good cures for blepharitis when used both externally on the lids and externally on the body. Mild mercuric salve will discourage the pediculi.

Eczema of the lids is seen in the poorly nourished children who also have eczema of the body. It causes intense itching, redness and discomfort. Next to rheumatism, the disease is about the most uncomfortable that one can have. Treatment consists in keeping the lids free from moisture and using dusting powders or mild astringent salves, building up the general health and improving personal hygiene. The condition is a very discouraging one to treat.

Then there is the ever present sty or hordeolum which is a furuncular inflammation of the connective tissue of the lids near a hair follicle. In these conditions deep abscesses may develop which will burrow one-half to three-quarters of an inch into the lids. Styes should be opened and drained and compresses applied. The eye should not be bandaged.

In all of these blepharitis cases with inflammation along the edge of the lid, trichiasis or the dropping out of the eyelashes may occur. When the tissue regenerates, a secondary row is formed which often irritates the cornea.

Deformities of entropion, a turning in of the lid, cause the lashes to scratch the edge of the cornea and conjunctiva. Ectropion, a turning out of the lid, allows the tears to pour down on the face, injuring the cornea by lack of nutrition.

The chalazion, sometimes mistaken for a sty, is a blocking up of the mouth of the Meibomian glands which are situated at the base of the eyelashes. These gland openings are occluded and the secretion from the glands is spread between the layers of the conjunctiva. If no infection develops this condition merely causes discomfort, since the chalazion may continue to grow and sometimes makes the lid droop by its own weight.

Chalazia should be opened under careful asepsis and the gelatinous material found in them removed. The glands may then function again without any severe results. When they become infected, however, they should be treated as an ordinary sty.

Of the congenital anomalies, epicanthus is the most common. Here the inner canthus of the eye is pulled down. This condition is most commonly seen in the Yellow race. A child having this condition is frequently nicknamed "Chink" because of the similarity in appearance. Surgical interference is the only cure.


The next anomaly which is frequently found is coloboma of the lid. A V-shaped piece missing at birth pulls the lid up so that the lid looks as if it were cut with a piece of glass.

Symblepharon is found occasionally. In this condition one lid is fastened to the other and is disconnected only by a surgical procedure.

Among other congenital anomalies is ptosis, or the inability to open the eyes, due to paralysis of the facial nerve.

The most common manifestation of syphilis of the lids is secondary blepharitis. This is indicated by a thickening at the edge of the lid and of the tarsal cartilage, or tarsitis, from an acute luetic attack. In adults a primary sore is occasionally found on the eyelid. Fortunately, all of these conditions yield very rapidly to careful antiluetic treatment.

Herpes Zoster, otherwise known as shingles, is really not an eye disease, but is caused by a disturbance of the first division of the trigeminus, involving the side of the face and lids. The extreme pain which accompanies this uncommon disease can be alleviated somewhat by local treatment until nerve irritation diminishes.



Digitized by the Internet Archive
in 2016 with funding from
American Printing House for the Blind, Inc.

<https://archive.org/details/diseasesoflidsco00hrob>

card made